(DO NOT STAPLE)

Employee Enrollment Form

UnitedHealthcare®

To speed the enrollment process, please be thorough and fill out all sections that apply.

To Be Completed by Employer

Requested Effective Date of Coverage/Date of Change / /

Group Name

Policy Number

Date of Hire / /

Position/Title

Hours Worked per week

Salary $____________

Reason for Application
☐ New Group Plan
☐ Life Event/Date_______
☐ Status Change_______
☐ Dependent Add/Delete
☐ Change Name/Address
☐ Part time to Full time
☐ Waiving Coverage
☐ Other ______________________
☐ New Hire
☐ Annual Open Enrollment
☐ Late Enrollee
☐ Termination

Employee Type
(Check all that apply)
☐ Active ☐ COBRA ☐ State Continuation
Start dt ____/____/____
End dt____/____/____
☐ Hourly ☐ Salary
☐ Union ☐ Non-Union ☐ Retired
☐ Other ____________________________

A. Employee Information

If you are waiving all coverage, please complete sections A and F.

Last Name	First Name	MI	Social Security Number
			___ – __ – ____

Address	Apt #	City	State	Zip Code	Home/Cell Phone

Date of Birth	Gender	Email Address	Work Phone
/ /	☐ M ☐ F		

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Language Preference, if not English

Do you use tobacco?[1] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___|___|___|___|___|___|___|___|___|___|___|___| – |___|___|

B. Family Information

List All Enrolling (Attach sheet if necessary)

Relationship[3]	Last Name	First Name	MI	Sex	Date of Birth
Spouse /Domestic Partner	Social Security Number: ___ – __ – ____			☐ M ☐ F	/ /

Do you use tobacco?[1] ☐ Yes ☐ No
If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Primary Care Physician[2] Existing Patient? ☐ Yes ☐ No

Physician First & Last Name ______________________________

Address ______________________________

ID# ___|___|___|___|___|___|___|___|___|___|___|___| – |___|___|

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence. (2) For UnitedHealthcare Compass, Navigate, Select, Select Plus, and other products requiring you to choose a Primary Care Physician (PCP), you must use the UnitedHealthcare directory of providers to choose a PCP for yourself and each of your covered dependents. (3) For court ordered dependent, legal documentation must be attached. If a dependent does not reside with eligible employee, please provide address on a separate sheet. (4) If you answered "Yes" for Disabled and the dependent child is 26 years of age or older, unmarried, chiefly dependent upon subscriber for support and is not able to be self-supporting because of a physically or mentally disabling injury, illness or condition, please attach a medical certification of disability.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of the Midwest, Inc.

Employee Name ______________________

B. Family/Dependent Information (continued)

List All Enrolling (Attach sheet if necessary)

Relationship[3]	Last Name	First Name	MI
Dependent	Social Security Number ___ — __ — ____	Sex ☐ M ☐ F	Date of Birth / /

Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Permanently disabled and age 26 or older[4] ☐ Yes ☐ No

Primary Care Physician[2]
Physician First & Last Name ______________________
Address ______________________
ID# ___|___|___|___|___|___|___|___|___|___|___| – |___|___|
Existing Patient? ☐ Yes ☐ No

Relationship[3]	Last Name	First Name	MI
Dependent	Social Security Number ___ — __ — ____	Sex ☐ M ☐ F	Date of Birth / /

Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Permanently disabled and age 26 or older[4] ☐ Yes ☐ No

Primary Care Physician[2]
Physician First & Last Name ______________________
Address ______________________
ID# ___|___|___|___|___|___|___|___|___|___|___| – |___|___|
Existing Patient? ☐ Yes ☐ No

Relationship[3]	Last Name	First Name	MI
Dependent	Social Security Number ___ — __ — ____	Sex ☐ M ☐ F	Date of Birth / /

Do you use tobacco?[1] ☐ Yes ☐ No If yes, are you currently participating in a tobacco cessation program or do you intend to join one? ☐ Yes ☐ No

Permanently disabled and age 26 or older[4] ☐ Yes ☐ No

Primary Care Physician[2]
Physician First & Last Name ______________________
Address ______________________
ID# ___|___|___|___|___|___|___|___|___|___|___| – |___|___|
Existing Patient? ☐ Yes ☐ No

C. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling. If your employer offers a choice of plans, indicate which plan you are selecting. Benefit offerings are dependent upon employer selection.

Person	Medical	
Employee	☐ ______	**This health benefit plan does not include coverage for elective abortions.**
Spouse [Domestic Partner]	☐	
Dependent	☐	

Exclusive Provider Organization Notice

This notice applies to managed care health benefit plans that require all health care services be delivered by providers participating in our network.

With the exception of emergency medical conditions, life-threatening conditions, disabling degenerative disease treatments, and certain mental health benefits, this health benefit plan covers only services received by providers participating in our network.

You can opt-out of this health benefit plan and be enrolled in a health benefit plan which includes out-of-network benefits by checking the box on the right. ☐

Employee Name _____

D. Prior Medical Insurance Information

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?
☐ NO ☐ YES (if yes, please complete this section.)

Prior medical carrier name _____ Effective date ___/___/___ End date ___/___/___

Prior coverage type: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Family

E. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date MM/DD/YY	End Date MM/DD/YY	Name and date of birth of policyholder for other coverage
Employee:				
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Are you receiving Social Security Disability Insurance (SSDI)? ☐ YES ☐ NO Start Date ___ /___ /___

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)**
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)**
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)**

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

** If you are eligible for Medicare on a primary basis (Medicare pays before benefits under the group policy), you should enroll in and maintain coverage under Medicare Part A, Part B, and/or Part D as applicable.

F. Waiver of Coverage

I decline all coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.

Date	Employee Signature if waiving coverage

G. Signature

I authorize UnitedHealthcare Insurance Company and its affiliates (collectively, "UnitedHealthcare") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

Please maintain a copy of this authorization for your records.

Date	Employee Signature for all applying	Spouse Signature (if applying for coverage)

H. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: ☐ White ☐ Black, African-American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other Race, please specify_____

2. Are you of Hispanic or Latino origin? ☐ Yes ☐ No